Supreme Court, U.S.
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In the Supreme Court of the United States

Term, 1994

DOROTHY E. TRAVITZ,

Petitioner

vs.

NORTHEAST DEPARTMENT ILGWU
HEALTH AND WELFARE FUND
AND
ILGWU EASTERN STATES
HEALTH AND WELFARE FUND

Respondent

Petition for Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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STATEMENT OF QUESTIONS PRESENTED FOR REVIEW

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1. Whether a court can ignore federal common law principles of contractual interpretation when construing the clear, unambiguous and unequivocal provisions of an Employee Retirement Income Security Act of 1974, ("ERISA"), 29 U.S.C. §1001, *et seq.*, Health and Welfare Plan (the "Plan") merely because it concludes that ERISA preempts a given state statute—in this case, Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. §1722?

2. Whether ERISA Plan fiduciaries are, under the federal common law principle of estoppel, precluded from making arguments inconsistent with a health care plan which on its face confers certain health benefits unless the treatment or service is "paid" under a plan or policy of motor vehicle insurance or "payable" by the Catastrophic Loss Trust Fund?

3. Whether §1722 of the Pennsylvania Motor Vehicle Financial Responsibility Law "relates to" employee welfare benefit plans merely because it contains a "reference to" benefit plans governed by ERISA or whether §1722 lacks a "connection with" such plans and falls within the "remote and peripheral" exception to ERISA preemption?

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1
Parties to the Proceedings

PARTIES TO THE PROCEEDING

The only parties to the proceeding are those appearing in the caption of the case.

CONSTITUTIONALITY OF A STATE OR FEDERAL STATUTE

Plaintiff has not raised as an issue the constitutionality of a state or federal statute.

REFERENCE TO THE OFFICIAL OPINIONS DELIVERED IN THE COURTS BELOW

The United States District Court for the Middle District of Pennsylvania issued a Memorandum and Order dated April 9, 1993, and three separate Orders to effectuate the ruling contained in its April 9, 1993, Memorandum, which have not been officially reported. The Third Circuit Court of Appeals affirmed, 13 F.3d 704 (3d Cir. 1994). The District Court's April 9, 1993, Memorandum and Order, as well as its subsequent Orders and the Third Circuit's Opinion, are reproduced in the Appendix, attached to this Petition for Writ of Certiorari.

STATEMENTS OF SUBJECT MATTER JURISDICTION AND APPELLATE JURISDICTION

The Third Circuit Court of Appeals entered its Order affirming the Decision of the District Court for the Middle District of Pennsylvania on January 10, 1994. The Petition for Writ of Certiorari was filed within ninety (90) days of that date and the jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

RELEVANT CONSTITUTIONAL STATUTES AND ORDINANCES INVOLVED

Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. §1722:

> §1722. **Preclusion of recovering required benefits.**
>
> "In any action for damages against a tortfeasor, or in any uninsured or underinsured motorist proceeding, arising out of the maintenance or use of a motor vehicle, a *person who is eligible to receive benefits* under the coverages set forth in this subchapter, or workers' compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719 (relating to coordination of benefits) *shall be precluded from recovering the amount of benefits paid or payable under this subchapter*, or workers' compensation, or any program, group contract *or other arrangement for payment of benefits as defined in section 1719*." (Emphasis added.)

Employee Retirement Insurance Security Act of 1974 (ERISA), 29 U.S.C. §1001, *et seq*.

STATEMENT OF THE CASE

Plaintiff, Dorothy E. Travitz, a 63-year-old widow, was involved in an automobile accident on October 18, 1990. Prior to her accident, Mrs. Travitz was a healthy, hard-working, active, physically and economically independent, self-sufficient individual. As a result of her accident, Dorothy Travitz sustained catastrophic injuries that resulted in significant medical bills and rendered her dependent upon others for many aspects of daily living. She has not and never will be able to return to work. She likewise has undergone and probably will continue to undergo various operations which have not and probably never will significantly improve her quality of life.

The Plaintiff's *past* accident-related medical expenses exceed $65,000. Additional medical expenses and surgeries are contemplated. The Plaintiff exhausted the $10,000 in medical benefits coverage available under her Prudential motor vehicle insurance policy and subsequently submitted the remaining accident-related medical expenses to the Defendant International Ladies Garment Workers Union (ILGWU) Fund plan for payment. Dorothy Travitz, at the time of the accident, was employed as a sewing machine operator by BR Apparel, Inc., was a member of ILGWU and was a participant in that Union's health and welfare benefit program. As of the date of the accident, October 18, 1990, certain amendatory changes in the Pennsylvania Motor Vehicle Financial Responsibility Law (PMVFRL) were in effect:

> §1722. **Preclusion of recovering required benefits.**
>
> "In any action for damages against a tortfeasor, or in any uninsured or underinsured motorist proceeding, aris-

> ing out of the maintenance or use of a motor vehicle, a *person who is eligible to receive benefits* under the coverages set forth in this subchapter, or workers' compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719 (relating to coordination of benefits) *shall be precluded from recovering the amount of benefits paid or payable under this subchapter*, or workers' compensation, or any program, group contract *or other arrangement for payment of benefits as defined in section 1719.*"

75 Pa. C.S.A. §1722 (emphasis added).

As a result of the recently-amended §1722, Mrs. Travitz could not and did not make any claim against the tortfeasor for her past and future medical expenses. In addition, the tortfeasor had a limited liability policy, which was paid. Mrs. Travitz only had $15,000 of underinsured motorist coverage, which was also paid.

Prior to the 1990 amendments, the PMVFRL contained a §1720 which provided:

> §1720. **Subrogation.**
>
> "In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to workers' compensation benefits, benefits available under section 1711 (relating to required benefits), 1712 (relating to availability of benefits) or 1715 (relating to availability of adequate limits) or benefits paid or payable by a program, group contract or other arrangement whether primary or excess under section 1719 (relating to coordination of benefits)."

In 1990, the Supreme Court of the United States in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), held that §1720 was

inapplicable to ERISA employment plans because ERISA had preempted the area. Although the ILGWU Fund initially paid $2,924.78 of medical bills, counsel for ILGWU relied upon *FMC Corp.*, and refused to pay additional medical expenses unless and until Mrs. Travitz signed a subrogation lien assignment. Upon advice of counsel, Mrs. Travitz refused to sign such an assignment. Because of the recently-enacted §1722 preclusion, Plaintiff's counsel pointed out the obvious distinction between §1720 and §1722 in relation to the specific exclusionary language contained in the Plan's Summary Plan Description:

> "Treatment
>
> You cannot receive benefits/coverage for a condition *if the costs of treating that condition are recoverable* through legal action or claim settlement from another party or insurance company." (Emphasis added.)

By the clear language contained in the Plan's exclusion, the Plan was required to pay medical benefits/coverage because federal common law required payment and because the 1990 amendatory §1722 precluded the recovery of medical bills. The Courts below ignored any federal common law analysis and disagreed with respect to the effects of §1722. Consequently the matter is before Your Honorable Court.

The goal of automobile insurance laws and ERISA plans is to preclude duplicate payment of benefits. The goal is not and should not be to preclude any recovery for medical bills from both automobile insurance and ERISA. If there is $100,000 of automobile insurance coverage available and a young father or mother is killed or rendered totally disabled with $100,000 worth of medical bills, medical coverage, whether automobile *or* private *or* ERISA, should pay the medical bills. That is all that is intended by automobile insur-

ance statutes and by the ERISA exclusion. This analysis was disregarded by the Courts below.

For these reasons, the Petitioner invokes Supreme Court Rule 10.1(c) and asserts that the United States Court of Appeals for the Third Circuit has decided "an important question of federal law which has not been, but should be, settled by this Court," and/or has decided "a federal question in a way that conflicts with applicable decisions of this Court." Supreme Court Rule 10.1(c).

REASONS FOR THE ALLOWANCE OF THE WRIT

A. A Court Cannot Ignore Federal Common Law Principles Of Contractual Interpretation When Construing The Clear, Unambiguous And Unequivocal Provisions Of An Employee Retirement Income Security Act Of 1974, ("ERISA"), 29 U.S.C. §1001, *et seq.*, Health And Welfare Plan (The "Plan") Merely Because The Court Concludes That ERISA Preempts A Given State Statute — In This Case, Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. §1722

The United States Court of Appeals for the Third Circuit, in its Decision filed January 10, 1994 (the "Opinion"), concluded that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §1001, *et seq.*, preempts Section 1722 of Pennsylvania's Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. §1722. The Opinion states that preemption is the "primary issue raised on this appeal." Opinion, Appendix p. 26a. In so concluding, the Opinion fails to consider Mrs. Travitz's alternative theory that despite preemption, a plain reading of the Plan, in light of the federal common law principles of contractual interpretation, shows that Mrs. Travitz is entitled to payment of her outstanding medical bills.

In the Courts below, Defendant argued, on one hand, that federal common law has developed under ERISA and should be applied with regard to the Defendant's claim against Plaintiff for unjust enrichment and, on the other, that this Court should not apply principles of federal common law in order to

ascertain whether the Plan acted inappropriately by construing unambiguous provisions to its own advantage.

The legislative history of ERISA indicates that Congress expected "that a federal common law of rights and obligations under ERISA-regulated plans would develop." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 56 (1987). Federal common law is not to be applied in such a manner that the rights of beneficiaries are determined solely by employee benefit plans and their fiduciaries. To do so would be akin to insurance companies determining insured's rights under life, health, medical and disability policies.

> *"If a court holds that federal common law dictates that the rights are determined solely by the employee benefit plan, then it essentially is holding that there is no federal regulation of this area of law. This outcome, however, does not appear to be what Congress intended.* Nowhere in the legislative history of ERISA does it appear that Congress wanted to reduce the substantive right of participants and beneficiaries by allowing self-insured plans to be unregulated. In fact, as noted earlier, the Supreme Court has stated that 'ERISA is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans.' Shaw, 463 U.S. at 90, 103 S.Ct. at 2896."

Wahl v. Northern Telecom Inc., 726 F. Supp. 235, 241 (E.D. Wis. 1989). (Emphasis added.)

Indeed, courts have been articulating what federal common law rules are to be applied in ERISA cases. Recently, the Court of Appeals for the Third Circuit joined several other Circuits in adopting *contra proferentum* as a federal common law rule in ERISA insurance cases. *Heasley v. Belden & Blake*

Corp., 2 F.3d 1249, 1257-58 (3d Cir. 1993); *Smith v. Hartford Ins. Group*, 6 F.3d 131, 139 (3d Cir. 1993).

Heasley was an ERISA case involving the interpretation of a contractual exclusion of medical benefits for a liver/pancreas transplant. The Court explained that the principle of *contra proferentum* derives from the recognition that:

> "[i]nsurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters' expertise and experience, *the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence*. Moreover, once the policy language has been drafted, it is not usually subject to amendment by the insured, even if he sees an ambiguity; an insurer's practice of forcing the insured to guess and hope regarding the scope of coverage requires that any doubts be resolved in favor of the party who has been placed in such a predicament." (Emphasis added.)

Heasley at 1257, quoting *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 540 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990).

The *Heasley* Court noted that this reasoning is especially convincing where, as here, an insured employee seeks contractual benefits under ERISA, a statute designed to protect the interests of such employees. *Heasley, supra* at 1257.

In *Smith, supra* the Third Circuit reaffirmed its adoption of the principle of *contra proferentum* in ERISA cases and clarified that the doctrine should be used only if formal principles of contractual construction are unavailing. *Smith, supra* at 140, n.9. Accordingly, the Court recognized that common

law principles of contractual construction would normally be applied in ERISA cases.

In the case at bar, the Court need not apply the doctrine of *contra proferentum*, because the application of normal principles of contract construction makes it clear that the Plaintiff is entitled to the benefits that she is seeking, and there are *no ambiguities* in the ERISA plan in question, or the statute in question. If the Court finds that there are ambiguities, however, it should apply *contra proferentum* and strictly construe such ambiguities against the insurer.

In conducting its review of the Defendant's denial of Plaintiff's claim for benefits under the Plan, the Court should not merely defer to the Defendant's interpretation of the Plan's provisions. Rather, it should apply federal common law, particularly common law concepts of contract interpretation, in a manner that is consistent with the legislature's intent to "protect ... the interests of participants in employee benefit plans and their beneficiaries." 29 U.S.C. §1001(b).

The Plan provides:

> "(3) You will *not* be covered ... *if* such treatment or service is *paid* under a plan or policy of motor vehicle insurance ... or *payable* by the Catastrophic Loss Trust Fund ...
>
> • • •
>
> (5) You can *not* receive benefits/coverage for a condition if the *costs* of treating that condition are *recoverable*. ..." (Emphasis added.)

The exclusion contained in the Fund's Summary Plan Description is as follows:

> "You cannot receive benefits/coverage for a condition *if the costs of treating that condition are recoverable*

through legal action or claim settlement from another party or insurance company." (Emphasis added.)

The advancement of benefits provision contained in the Fund's Summary Plan Description states:

> "*If you have a right to recover payment* for an injury or illness from another source, there may be delays because of the time it takes to process the claim or because of lawsuits. If this happens, the Fund may be able to help you temporarily by paying benefits in advance. If this is done, you must sign a legal document stating that the Fund will be repaid in full, from any settlement you receive. The Fund must be repaid to the *Full Extent* (without deduction of attorney fees, court costs, or arbitration costs) of the benefits it provided. The Fund may also require legal assurances that the party which is liable to you will honor your claim and that the money due to you will be repaid directly to the Fund. In all cases, only the Trustees of the Fund can decide whether an advance of benefits is appropriate. Each case will be decided on its own merits." (Emphasis added.)

All of these sections under the Plan use the unambiguous terms "paid," "recoverable," or "right to recover." It is clear that the purpose of these exclusions and limitations is to preclude duplicate recovery for the same injuries. If one cannot recover or has not recovered for the cost of treatment or services, then the exclusions and limitations do not apply.

Webster defines pay, paid, recover, recovered, recoverable as follows:

> " 'Paid.' 1: marked by the receipt of pay. 2: being or having been paid or paid for.
>
> 'Pay.' 1a: to make due return to for services rendered or property delivered. b: to engage for money ... 2a: to

give in return for goods or service .. .b: to discharge indebtedness for: settle ...

'Recover.' ... to receive ... 1: to get back: regain. ... 3b: to gain by legal process ... adj. recoverable."

Webster's Ninth New Collegiate Dictionary, 1989.

In the instant case, $10,000 of Mrs. Travitz's medical bills were paid by her automobile carrier under the Pennsylvania Motor Vehicle Financial Responsibility Law, 75 Pa. C.S.A. §1701, *et seq*. Under the 1990 amendments to that law, Mrs. Travitz could not sue for and/or recover the $10,000 paid by her automobile carrier. She simply has never been "paid" and has never "recovered" for those expended medical costs over and above the $10,000.

Historically, the law dealing with interpreting exclusions and limitations has been that unequivocal terms are naturally interpreted in accordance with their usual meanings. Even ambiguous terms are interpreted against the author of the exclusions and limitations. *In Re F.H. McGraw & Co.*, 473 F.2d 465 (3d Cir. 1973), *cert. denied*, 414 U.S. 1022 (1973); *Rusiski v. Pribonic*, 511 Pa. 383, 515 A.2d 507 (1986); *Second Federal Savings and Loan Assn v. Brennan*, 409 Pa. Superior Ct. 581, 598 A.2d 997 (1991).

The Defendants' exclusionary language is clear. Language that is clear, such as an exclusion, cannot be interpreted to mean other than what it plainly says. *Guardian Life Ins. Co. v. Zerance*, 505 Pa. 345, 479 A.2d 949 (1984); *Standard Venetian Blind Co. v. American Empire Ins. Co.*, 503 Pa. 300, 469 A.2d 563 (1983); *Patton v. Patton et al.*, 413 Pa. 566, 198 A.2d 578 (1964).

The Defendant should not be permitted to torture the clear language of the Plan in order to create an ambiguity.

Houghton v. American Guaranty Life Ins. Co., 692 F.2d 289 (3d Cir. 1982).

Congressional intent is one of the touchstones that exists to help a federal court determine what substantive rights federal common law should create or deny. The legislature's intent in enacting ERISA can be found at 29 U.S.C. §1001(b), which explicitly declares:

> "... to be the policy of this Act *to protect* interstate commerce and *the interests of participants in employee benefit plans and their beneficiaries*, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the federal courts." (Emphasis added.)

ERISA was enacted not to shield employee welfare benefit plans from their responsibility to provide benefits, but rather to protect the interests of participants in such plans.

In order to determine the effect of the preemption of §1722 of the Pennsylvania Motor Vehicle Financial Responsibility Law by ERISA in the case at bar, the Court must apply federal common law in a manner consistent with congressional intent after carefully considering the Plan provisions in question.

The Court below simply failed to fulfill its duty to develop the federal common law in this area but rather, merely concluded that because of the preemption issue, no further inquiry need be made.

B. ERISA Plan Fiduciaries Are, Under The Federal Common Law Principle Of Estoppel, Precluded From Making Arguments Inconsistent With A Health Care Plan Which On Its Face Confers Certain Health Benefits Unless The Treatment Or Service Is "Paid" Under A Plan Or Policy Of Motor Vehicle Insurance Or "Payable" By The Catastrophic Loss Trust Fund

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Had it so chosen, the Fund could have drafted a general right to subrogation into its Summary Plan Description. It did not do so, and should not now be permitted to torture the plain language of the exclusion in an attempt to assert such a right. The Defendant Fund formulated and established the terms of its program and cannot now argue that its own terms are ambiguous and mean something different than is plainly stated. The Plan is estopped from challenging the terms of its own program. *West American Ins. Co. v. Park*, 933 F.2d 1236 (3d Cir. 1991) (and cases cited therein).

Defendant asserted in the Courts below that it has discretion to interpret the language contained in a Summary Plan Description. However, such discretion may only be exercised if there is an ambiguous or uncertain term. In the instant case, there is no ambiguity. Language that is clear, such as the exclusion, cannot be interpreted to mean other than what it plainly says. *Guardian Life Ins. Co. v. Zerance, supra*. As there is no question concerning the language that is contained in the exclusion and relied upon by the Defendant, the Defendant does not have discretion to improperly interpret terms that are unambiguous and not in need of any further clarification. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989); *Luby v. Teamsters Health, Welfare, and Pension Trust Funds*, 944 F.2d 1176, 1180 (3d Cir. 1991).

The Plan in question contains no general subrogation clause. Rather, the language in exclusion number 5 provides:

> "You cannot receive benefits/coverage for a condition *if the costs of treating that condition are recoverable* through legal action or claim settlement from another party or insurance company." (Emphasis added.)

Had the Defendant Plan so chosen, it could easily have drafted subrogation and reimbursement language into its Plan which would have provided for reimbursement in the event that any recovery was made by the Plan beneficiary. It did not do so, and should not now be permitted to change clear language in an attempt to create a provision that it chose not to include in the Plan in the first place.

In the instant case, Mrs. Travitz was very seriously injured. She incurred medical bills totalling $63,058.42. In addition to incurring $63,058.42 of medical expenses, she was rendered totally disabled by the accident and will never be able to return to remunerative labor. She also will forever walk only with assistance. She has sustained and will sustain pain and suffering and endure a loss of life's pleasures. There was only $365,000 of liability and underinsured motorist coverage. She had to pay $104,483.98 in attorney's fees. Her settlement was structured so as to give her a little bit of money over her lifetime. She continues, however, to incur medical expenses and may well incur very substantial medical expenses for operations in the future. Under Defendant's interpretation, even if a judge concluded that Mrs. Travitz could not sue for medical bills because they are not recoverable under §1722 of the Pennsylvania Motor Vehicle Financial Responsibility Law, even if a jury awarded her $500,000 for loss of earnings, impairment of earning capacity, pain and suffering, loss of life's pleasures, etc., even if there were only $365,000 of liability and

underinsured motorist coverage, Defendant contends it would not have to pay Mrs. Travitz's medical bills—past, present or future. Interestingly, the Plan's exclusion does not even provide for any deduction for attorney's fees and expenses, meaning that the Plan would interpret the gross jury verdict, or at least the total liability coverage, as "recoverable." If Mrs. Travitz had also paid an additional premium to buy disability insurance, Defendant would contend that same was a recovery as a result of personal injuries in a motor vehicle accident and, presumably, punitive damages, and almost any other type of damage or award would fit within the Plan's interpretation. This cannot be the law and still comport with state or federal common law principles of estoppel.

C. Alternatively, Although §1722 Of The Pennsylvania Motor Vehicle Financial Responsibility Law "Relates To" Employee Welfare Benefit Plans Because It Contains A "Reference To" Benefit Plans Governed By ERISA, §1722 Lacks A "Connection With" Such Plans And Falls Within The "Remote And Peripheral" Exception To ERISA Preemption

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The 1990 amendments to the PMVFRL added §1722 as a "preclusion of recovering" from tortfeasors any medical bills paid by "any program."

It should be pointed out, in addition, that §1722 deals primarily with the types of damages that can be recovered in Pennsylvania and only remotely touches upon ERISA benefit plans.

While Mrs. Travitz obviously concedes that §1722 contains a "reference to" employee welfare benefit plans, as it contains essentially the same language regarding benefits

"paid or payable" under §1719 as does §1720, Section 1722 lacks a "connection" with ERISA benefit plans, and affects such plans in such a remote and peripheral manner as to warrant a finding that it falls within the "remote and peripheral" exception to the ERISA preemption.

Your Honorable Court has recognized that "[s]ome state actions may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983). It has been held that the "remote and peripheral" exception to ERISA preemption may apply even if a state's statute "relates to" an employee benefit plan. In *Liberty Corp. v. NCNB National Bank of South Carolina*, 786 F. Supp. 552, 554 (D.S.C. 1992), the South Carolina District Court found that "even if the North Carolina Wrongful Death Act did 'relate to' the plan, the Act falls within the 'remote and peripheral' exception to ERISA preemption."

Like North Carolina, every state has an interest in determining what damages may or may not be recoverable for accidents occurring within the state or involving state domicilaries or residents. Pennsylvania, like other states, has an interest in protecting the public funds and maintaining reasonable insurance rates. As a result, Pennsylvania at one time prohibited suits against charities, governments, between certain family members, etc. Pennsylvania, in numerous statutes, also has precluded the recovery of medical bills that are paid or payable under medical insurance contracts or plans. *See*, 75 Pa. C.S.A. §1722 (Pennsylvania Motor Vehicle Financial Responsibility Law); 42 Pa. C.S.A. §8553(d) (Political Subdivision Tort Claims Act); 75 Pa. C.S.A. §1755(b) (Assigned Claims Plan); and 40 P.S. §1301.602 (Health Care Services Malpractice Act).

Logically and practically, there should be no difference between statutes which provide that certain individuals and entities may not be sued, medical damages may not be recovered, or medical bills that are paid or payable under insurance contracts or plans may not be recovered. As a point of fact, *states*, rather than the federal government, have been given jurisdiction in regulating the insurance industry which is an integral part of the aforementioned statutes.

As noted by the Sixth Circuit in *Firestone Tire & Rubber Co. v. Neusser*, 810 F.2d 550 (6th Cir. 1987), three factors are used in order to determine whether the "remote and peripheral" exception should apply. The factors are: (1) whether the state law represents a traditional exercise of state authority; (2) whether the state law affects the relations among the employer, the plan fiduciary and the plan beneficiaries, rather than the relations between one of those entities and an outside party, or between two outside parties; and (3) whether the state law's effect on the ERISA plan is incidental. *Id.* at 555-556.

In the instant case, each of these factors favors the application of the exception. First, §1722 clearly represents a traditional exercise of state authority—it serves to define the damages which may not be recovered from a third party in an action arising out of the maintenance or use of a motor vehicle. Second, unlike §1720 of the Motor Vehicle Financial Responsibility Law, which clearly affects the relationship between a Plan and the Plan's beneficiaries by precluding the exercise of subrogation rights, §1722 affects the relations between a Plan beneficiary and an outside party (the tortfeasor against whom the action was filed). Finally, the effect of §1722 upon ERISA Plans in general and the Defendant Fund in particular is incidental. §1722 merely defines an individual's right of recovery in an action against a third party. The Plan's exclusion is

limited to instances where a party is entitled by state law to recover for medical benefits.

The Courts below erroneously held that §1722 fell within the ERISA preemption clause because it "relates to" ERISA benefit Plans and because "it is connected to ERISA because, like §1720, it risks subjecting plans such as the Fund to conflicting legal requirements from different states." A careful reading of §1722, however, reveals that such is not the case.

In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Supreme Court found that §1720 of the Pennsylvania Motor Vehicle Financial Responsibility Act had a "connection" to ERISA benefit Plans, noting that:

> "Pennsylvania's antisubrogation law prohibits plans from being structured in a manner requiring reimbursement in the event of recovery from a third party. It requires plan providers to calculate benefit levels in Pennsylvania based on expected liability conditions that differ from those in States that have not enacted similar antisubrogation legislation. Application of differing state subrogation laws to plans would therefore frustrate plan administrators' continuing obligation to calculate uniform benefit levels nationwide."

Id. at 60.

There is a marked difference between the subrogation language contained in the *FMC* employee welfare benefit Plan (... program is automatically assigned to the right of action against third parties in any situation in which benefits are paid ...) and the language in the Plan at issue, which make such rights dependent upon "a right to recover." *FMC Corp v. Holliday*, dealing with §1720 and totally different Plan language, has no precedential effect in the instant case. Furthermore, a careful reading of §1722 of the Pennsylvania Motor

Vehicle Financial Responsibility Act reveals that it has no such effect upon ERISA benefit Plans. It does not prohibit Plans from being structured in a manner requiring reimbursement in the event of recovery from a third party; it does not require Plan providers to calculate benefit levels in Pennsylvania based upon expected liability conditions that differ from those in states that have not enacted similar anti-subrogation legislation; it does not serve to frustrate Plan administrators' obligation to calculate uniform benefit levels nationwide.

If an ERISA Plan wishes to avoid paying for medical expenses incurred as a result of an accident caused by a third party, it need merely draft such a provision and include it in the Plan for it to have nationwide effect. Similarly, if an ERISA Plan wishes to be reimbursed for accident-related medical expenses that it pays on behalf of a Plan participant who may recover such expenses in a third-party action, it need merely include a provision in the Plan which states that it would have a right to reimbursement of or subrogation against any third-party settlement or verdict that the Plan participant might obtain. Again, such a simple provision would have nationwide effect and would not require Plans to calculate benefit levels based on expected liability conditions that differ from state to state.

In the case at bar, the Defendant Fund, which was master of the contract, could have, but chose not to, include such provisions in its Plan document and Summary Plan Description. Instead, it drafted a broader provision which stated that:

> "You cannot receive benefits/coverage for a condition *if the costs of treating that condition are recoverable* through legal action or claim settlement from another party or insurance company." (Emphasis added.)

The Defendant Fund, which chose not to implement a more far-reaching right of reimbursement, should not now be permitted to escape its obligations by making the blanket assertion that §1722 has the same "connection" to, and effect upon, ERISA benefit plans as §1720, and that ERISA preemption should therefore apply.

CONCLUSION

Throughout the country in recent years various states including Pennsylvania have passed automobile insurance laws precluding the recovery of medical bills where injured victims are "covered" by employer medical plans. Third-party suits are permitted only for "non-covered" medical expenses, lost earnings, disability, death and general damages. At the same time many ERISA Plans provide for exclusions when an injured victim is "covered" by automobile insurance. The goal of automobile insurance laws and ERISA Plans is to preclude duplicate payment of benefits. The goal is not and should not be to preclude any recovery for medical bills from both automobile insurance and ERISA. If there is $100,000 of automobile insurance coverage available and a young father or mother is killed or rendered totally disabled with $100,000 worth of medical bills, medical coverage, whether automobile *or* private *or* ERISA, should pay the medical bills. That is all that is intended by automobile insurance statutes and by the ERISA exclusion.

The language utilized in Plan documents, like any other contracts, is subject to reasonable interpretations based upon generally accepted definitions and meanings and common law principles governing unambiguous and ambiguous terms. Fiduciaries of Plans cannot be permitted to torture the language in the Plans so as to deprive employees of bargained-for benefits. The language similarly cannot be tortured beyond recognition to the extent that any recovery from any source eliminates the Plan's responsibility to pay medical bills even if the medical bills have not been paid and cannot be recovered.

Conclusion

ERISA was enacted in order to *protect* the interests of *participants* in employee benefit plans and their beneficiaries. The language contained in §1722 of the Motor Vehicle Financial Responsibility Law precluded the recovery of medical expenses. The limited liability limits and the other facts and circumstances of the case resulted in Mrs. Travitz recovering nothing for her medical bills beyond the $10,000 paid by her own automobile carrier. Mrs. Travitz was not paid, did not recover, and could not recover for her medical bills beyond the $10,000 paid by her carrier. Consequently, the Plan must be forced to pay the outstanding medical bills and any bills incurred in the future. Only then will ERISA be interpreted as intended to protect the interests of participants.

Respectfully submitted,
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PROOF OF SERVICE

I hereby certify that I, Richard C. Angino, Esquire, on the 8th day of April, 1994, have served a true and correct copy of the foregoing Writ of Certiorari upon counsel of record via postage pre-paid, first-class United States mail addressed as follows:

Charles W. Johnston, Esquire
Handler, Gerber, Johnston & Aronson
150 Corporate Center Drive, Suite 100
Camp Hill, PA 17011-0098

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-92-0922

DOROTHY E. TRAVITZ,

Plaintiff

v.

NORTHEAST DEPARTMENT ILGWU HEALTH AND WELFARE FUND AND ILGWU EASTERN STATES HEALTH AND WELFARE FUND,

Defendants

MEMORANDUM

Before the court are the parties' cross-motions for summary judgment. The motions are ripe for disposition.

Background

The following facts are essentially undisputed. Plaintiff Dorothy Travitz is a Pennsylvania resident. In 1990 she was an employee of BR Apparel, Inc., a member of the International Ladies' Garment Workers' Union ("ILGWU"), and a participant in that union's health and welfare program. Defendants Northeast Department ILGWU Health and Welfare Fund and ILGWU Eastern States Health and Welfare Fund were providers of benefit programs for members of the ILGWU. In January 1990, these two funds merged into a single entity, the ILGWU Eastern States Health and Welfare Fund ("the Fund"), which is the surviving union health and welfare plan, with offices in New York City.

On October 18, 1990, Plaintiff was seriously injured in a motor vehicle accident. According to Plaintiff, her accident-related medical expenses exceeded $65,000. She exhausted

the available medical benefits coverage on her Prudential motor vehicle insurance and subsequently filed both a claim against the tortfeasor responsible for the accident, and an underinsurance claim with Prudential. She apparently exhausted the Prudential coverage. She reached a settlement with the tortfeasor on June 17, 1992.[1]

Subsequent to the accident, Plaintiff made various claims under the ILGWU Fund plan for medical benefits which remain unpaid. She brought the captioned action to recover the benefits, as well as to clarify her rights to future benefits. According to her complaint, she seeks bad faith damages as well as the benefits, attorney's fees, costs, and interest. The complaint asserts federal jurisdiction on diversity grounds and presents no explicit legal doctrine to justify the claims.

Defendants have counterclaimed for reimbursement of $2,924.78 in advance payments made to Plaintiff for medical expenses allegedly excluded from Fund coverage, but advanced until Plaintiff recovered from the relevant third party(s) or tortfeasor(s). Plaintiff argues that since the medical expenses were improperly excluded from coverage, the subject payments were not "advances" and need not be reimbursed.

Legal Discussion

I. Motions for Summary Judgment.

The court will consider these cross-motions under the accepted standards for the award of summary judgment under Rule 56 of the Federal Rules of Civil Procedure. Summary judgment is appropriate where there are no remaining issues

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[1] *See* Settlement Agreement and Release, Defendants' exhibits to Obrenz Aff., no. 16. The parties settled for $125,000 plus four guaranteed scheduled payments ranging from $10,000 to $30,000, plus $1,030 per month for life. *Id.*

of material fact to be decided, and one party is entitled to judgment as a matter of law. *Hankins v. Temple Univ.*, 829 F.2d 437, 440 (3d Cir. 1987). In examining Rule 56 motions, the court must consider "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986).

The parties' burdens in summary judgment may be described in the following way: Once the moving party has shown an absence of evidence to support the claims of the non-moving party, the non-moving party must do more than simply sit back and rest on the allegations in her complaint. She must "go beyond the pleadings and by her own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts showing that there is a genuine issue for trial.'" *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986). If the non-movant bears the burden of persuasion at trial, the moving party may meet its burden by showing that the evidentiary materials of record, if reduced to admissible form, would be insufficient to carry the non-movant's burden at trial. *Chipollini v. Spencer Gifts, Inc.*, 814 F.2d 893, 896 (3d Cir.), *cert. dismissed*, 483 U.S. 1052 (1987).

II. Is the Fund a Self-Insured ERISA Plan?

From the outset of this action, Defendants have asserted that the Fund is a multi-employer health and welfare plan within the meaning of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §1001 *et seq.* Defendants' legal arguments in the captioned action depend on the Fund being an ERISA plan.

However, Plaintiff has never, in either responsive or reply briefs, addressed the Fund's status under ERISA, or submitted any evidence to controvert Defendants' position on this point.

In fact, Plaintiff's arguments seem to implicitly accept the fact that the ILGWU Fund is an ERISA plan. (*See, e.g.*, Plaintiff's brief in support at 6-8.)

Defendants have submitted the affidavit of the Fund director, which states that the Fund has always been a multi-employer plan within the meaning of ERISA. (*See* Aff. of Bert N. Obrentz ("Obrentz Aff.") at ¶ 3, p.2.) It provides medical, disability, and preventative health care, as well as vacation benefits to employees of contributing union employers. *(Id.)* As per collective bargaining agreements, plan benefits are funded by employer contributions and the income earned on them. *(Id.)* The Fund has a published Plan, Rules, and a Summary Plan description available to individuals upon request and routinely supplied to union affiliates. Defendants have supplied copies of these documents as exhibits.[2] The Fund has ongoing agreements with Blue Cross and Blue Shield to administer its hospital, medical, and major medical benefits; the Fund itself remains solely responsible for the payment of such benefits. These agreements have also been included as exhibits by Defendants.[3]

After viewing the above documents, and given the lack of any controverting evidence from Plaintiff, this court concurs with Defendants that the subject Fund is a multi-employer employee welfare benefit plan covered by ERISA. *See* 29 U.S.C. §1002 (1), (4), (37A) (definitions of employee welfare plan, employee organization, multi-employer plan); 29 U.S.C. §1003 (coverage of ERISA); 29 U.S.C. §1102 (a), (b) (establishment and requisite features of employee benefit plan). The

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[2] *See* Defendants' exhibits to Obrentz Aff., nos. 3-5 (Plan, rules, and summary plan description of the Fund).

[3] *See* Defendants' exhibits to Obrentz Aff., nos. 6-10 (agreements with Blue Cross, Blue Shield).

court further agrees that the Fund is a self-insured ERISA plan.

III. What is Plaintiff's Cause of Action and What Is the Standard of Review?

As the court stated earlier, the captioned Complaint cites facts and the desired outcome but no explicit legal doctrine. It makes no mention of ERISA. Because the Complaint requests "bad faith" damages, a state law concept, the court infers that Plaintiff's action was intended as one under state law, perhaps for breach of contract.

Since the court has decided that the Fund is an ERISA plan, ERISA itself circumscribes the causes of action available to plan participants. ERISA is a comprehensive piece of legislation which contains three provisions pertaining to its preemptive effect on law. ERISA §514(a), the so-called "preemption clause," provides,

> Except as provided in subsection (b) [ERISA savings clause] of this section, the provisions of this subchapter and subchapter II of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. ...

29 U.S.C. §1144(a).[4] ERISA §514(b)(2)(A), the "savings clause," provides,

> Except as provided in subparagraph (B) [ERISA deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

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[4] State criminal laws are generally exempt from this preemption provision. *See* 29 U.S.C. §1144(b)(4).

29 U.S.C. §1144(b)(2)(A) ERISA §514(b)(2)(B), the "deemer clause," provides,

> Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

29 U.S.C. §1144(b)(2)(B). Whatever else these three provisions encompass, it is clear that they result in the preemption of state common law causes of action to recover medical benefits, such as breach of contract. Such causes of action relate to employee benefit plans, and are thus within the scope of the "preemption clause," but are not specifically directed at the regulation of insurance, banking or securities and thus not saved under the "savings clause." *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 47 (1987). As the United States Supreme Court has detailed, Congress intended that the deliberately extensive civil enforcement scheme contained in ERISA §502(a), 29 U.S.C. §1132(a), be the exclusive vehicle for actions by plan participants and beneficiaries asserting improper benefits processing. *Id.* at 52-54.

Under ERISA §502(a)(1)(B), 29 U.S.C. §1132(a)(1)(B), a plan participant may bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. §1132(a)(1)(B). The court will deem Plaintiff's action to be one under ERISA §502(a)(1)(B).

In actions under §1132(a)(1)(B), the United States Supreme Court has held that courts must review the denial of benefits under a *de novo* standard, unless the subject plan explicitly gives the plan administrator, or fiduciary, discretionary authority to determine eligibility for plan benefits or to construe the plan's terms. In those cases, courts must apply a more deferential standard of review, abuse of discretion. *Firestone Tire and Rubber Co. v. Bruch,* 489 U.S. 101, 115 (1989).

The captioned parties have disagreed over whether the Fund's fiduciaries have the appropriate discretion to trigger the more deferential standard of review. However, since the court would uphold the challenged denial of medical benefits under either standard of review, it need not decide which standard is triggered.

IV. The Terms of the Pennsylvania Statute and the Plan Provisions.

Plaintiff has relied on the following provision of the Pennsylvania Motor Vehicle Financial Responsibility Law:

> In any action for damages against a tortfeasor, or in any uninsured or under insured motorist proceeding, arising out of the maintenance or use of a motor vehicle, *a person who is eligible to receive benefits under the coverages set forth in this subchapter,* or worker's compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719 (relating to coordination of benefits) *shall be precluded from recovering the amount of benefits paid or payable under this subchapter,* or worker's compensation, or any program, group contract or other arrangement for payment of benefits as defined in section 1719.

75 Pa. Cons. Stat. Ann. §1722 (1977 & 1992 Supp.) (emphasis added).

On the other hand, Defendants rely on Coverage Exclusion 5 of the Fund's Summary Plan Description (*see* Defendants' exhibits to Obrenz Aff., no. 5 at p. 43) which also appears in the Fund's Basic Plan. (*See id.*, no. 3, p. 12-13.)[5] Exclusion 5 reads:

> You can not* receive benefits/coverage for a condition if the costs of treating that condition are recoverable through legal action or claim settlement from another party or insurance company.

(Summary Plan Description, Defendants' exhibits to Obrenz Aff., no. 5, p. 43.)

The parties are embroiled in a "which came first, the chicken or the egg" dispute over which of the above provisions, the statute or the Exclusion, has primary effect. Plaintiff argues that the statutory provision, Section 1722, specifically precluded her from recovering medical expenses from the appropriate tortfeasor because they were payable under a medical benefit program. She contends that she is entitled to recovery

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[5] While Defendants' initial correspondence with Plaintiff's counsel indicated that Exclusion 5 was the reason for exclusion of Plaintiff's claims, (*see* letter of April 12, 1991, Defendants' exhibits to Obrenz Aff., no. 13), a later letter to Plaintiff's counsel cited both Exclusions 3 and 5. (*See id.*, no. 17.) Plaintiff characterizes Exclusion 3 as referring to the first $10,000 of medical coverage under motor vehicle insurance required by the Pennsylvania Motor Vehicle Financial Responsibility law. Defendants' letter to Plaintiff's counsel supports this interpretation. (*See id.* (stating terms of Exclusion 3 and stating that therefore the Fund would not pay benefits payable under Plaintiff's auto insurance coverage).) Plaintiff contends that Exclusion 3 is not relevant, because the benefits recovery sought by Plaintiff does not include the first $10,000 of medical expenses paid by her Prudential policy. Defendants do not seriously controvert this, and the major portion of both parties' pleadings are devoted to Exclusion 5. Hence, in its examination, the court will consider only Exclusion 5; the appropriate concern is whether there was *any* ground to withhold Fund coverage.

of her accident medical expenses from the Fund since the statute precluded her from recovery of them from the appropriate third party(s).

However, Defendants contend that their Fund's Exclusion 5 is primary. According to them, Exclusion 5 made the accident medical coverage unavailable to Plaintiff, who was properly denied coverage under its clear and explicit terms. Therefore, even under the terms of the statute, Plaintiff could have pursued recovery of medical benefits from the appropriate third party. The Fund defends its decision and argues that Section 1722 cannot apply to a self-insured ERISA benefit plan so as to regulate or change the benefits offered by it. Section 1722 is "preempted" to the extent it can be read to do this.

The court concludes that Defendants have the more correct legal interpretation. Plaintiff's interpretation, that the statute has primary effect, would essentially permit Pennsylvania law (§1722) to regulate benefit coverage provisions of a self-insured ERISA benefit plan. Such an interpretation would put the Fund in the position of having to tailor its provided benefits to the locale of the beneficiary. Recent case law demonstrates that both of these results are unacceptable departures from the intentions of Congress in enacting ERISA.

In considering issues of preemption, the United States Supreme Court has found that the touchstone is Congressional intent. *See, e.g., FMC Corp. v. Holliday,* 498 U.S. 52, 111 S. Ct. 403, 407 (1990). In this instance, Congress provided three ERISA clauses which relate expressly to the preemption issue:[6]

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[6] For the explicit wording of the preemption, saving, and deemer clauses, *see* p. 6-7, *supra.*

> [The preemption clause] establishes as an area of exclusive federal concern the subject of every state law that "relate[s] to" an employee benefit plan governed by ERISA. The saving clause returns to the States the power to enforce those state laws that "regulat[e] insurance," except as provided in the deemer clause. Under the deemer clause, an employee benefit plan governed by ERISA shall not be "deemed" an insurance company, an insurer, or engaged in the business of insurance for purposes of state laws "purporting to regulate" insurance companies or insurance contracts.

Id. After examining Congressional intent, the Supreme Court has found that ERISA's preemption clause has a broad reach. ERISA's legislative history indicates that Congress explicitly rejected a preemption provision that would have been limited to state laws dealing explicitly with ERISA plans. *See id.* at 408, n.3.

Instead, "Congress used the words 'relate to' ... in their broad sense. It did not mean to pre-empt only state laws specifically designed to affect employee benefit plans." *Id.* at 408. "A law 'relates to' an employee benefit plan ... if it has a connection with or reference to such a plan." *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 111 S. Ct. 478, 483 (1990) (quoting *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85, 96-97 (1983)). "[A] state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand Co.,* 111 S.Ct. at 483. *See also FMC,* 111 S.Ct. at 408. Preemption is not precluded "simply because a state law is consistent with ERISA's substantive requirements." *Id.*

Defendants have relied heavily on *FMC Corp. v. Holliday,* 498 U.S. 52, Ill S. Ct. 403 (1990), in which the Supreme

Court held that §1720, a different provision of the same Pennsylvania Motor Vehicle Financial Responsibility Law involved in the instant action, was preempted by ERISA. Plaintiff's attempt to distinguish the facts in FMC from the facts in the captioned case[7] ignores the overarching general legal conclusions drawn from previous Supreme Court cases and asserted in *FMC*.

The Supreme Court held in *FMC* that §1720 "related to" ERISA, within the meaning of the ERISA "preemption clause," because §1720 "referred" to ERISA-governed plans, in its mention of "benefits ... paid or payable under section 1719," in much the way that §1722, the subject provision in the captioned case, does.

In addition, the Supreme Court found that §1720 also was "connected to" ERISA because, like §1722 in the captioned action, §1720 posed a risk that ERISA plan administrators would be subjected to conflicting regulations among different states, *FMC*, 111 S.Ct. at 408; since requiring ERISA plan providers to design programs in the presence of differing State regulations would complicate the administration of nationwide plans, produce inefficiencies that employers might offset with decreased benefits, and possibly frustrate the calculation and award of uniform benefit levels nationwide, the *FMC* Court "applied the preemption clause to ensure that benefit plans will be governed by only a single set of regulations." *Id.* at 408, 409. However, the *FMC* Court proceeded to find that §1720 also fell within the ERISA insurance "saving clause,"

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[7] *FMC* concerned the enforceability of an ERISA plan's subrogation clause in the face of a Pennsylvania statutory provision stating that "there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to ... benefits available ... or ... paid or payable under section 1719." 75 Pa. Cons. Stat. Ann. §1720. As stated above, the Supreme Court found that the Pennsylvania statutory provision was preempted by ERISA.

because §1720 would invalidate any subrogation provisions insurance policies might contain, and thus control the terms of insurance contracts. *Id.* at 409.

The *FMC* Court ultimately concluded that the ERISA "deemer clause" broadly exempted self-funded ERISA plans from the reach of §1720. The Court found that Congress did not intend the "deemer clause" to apply merely to those instances where a state uses insurance regulation as a pretext to impinge on core ERISA concerns. *Id.* at 410. Such an approach "would be fraught with administrative difficulties, necessitating definition of core ERISA concerns and of what constitutes business activity," undermining Congress' intent "to avoid endless litigation over the validity of State action." *Id.* at 409, 410. The Court stated that

> by forbidding States to deem employee benefit plans "to be an insurance company or other insurer ... or to be engaged in the business of insurance," the deemer clause relieves plans from state laws "purporting to regulate insurance." As a result, self-funded ERISA plans are exempt from state regulation insofar as that regulation "relates[s] to" the plans. ... State laws that directly regulate insurance are "saved" but do not reach self-funded employee benefit plans because the plans may not be deemed to be insurance companies, other insurers, or engaged in the business of insurance for purposes of such state laws. On the other hand, employee benefit plans that are insured are subject to indirect state insurance regulation ... [since] [a]n insurance company that insures a plan remains an insurer for purposes of state laws. ...
>
> By recognizing a distinction between insurers of plans and the contracts of those insurers which are subject to direct state regulation, and self-insured employee

> benefit plans governed by ERISA, which are not, we observe Congress' presumed desire to reserve to the States the regulation of the "business of insurance."

Id.

This court agrees with Defendants' interpretation of the relative effect of Exclusion 5 and Section §1722. Because Exclusion 5 precluded Plaintiff from collecting the medical benefits she sought, since they were recoverable from a third party, Plaintiff remained unconstrained under the Pennsylvania Motor Vehicle Financial Responsibility Law to seek those medical benefits from the appropriate tortfeasor(s). To the extent that one might read §1722 otherwise, to preclude or trump a self-funded ERISA plan provision such as Exclusion 5, §1722 is "preempted" by ERISA.

Section 1722 falls within the ERISA "preemption clause;" it "relates to" ERISA benefit plans, because it mentions benefit plans, and it is connected to ERISA because, like §1720, it risks subjecting plans such as the Fund to conflicting legal requirements from different states. While §1722 might be interpreted as a law regulating insurance under the ERISA insurance "savings clause," the ERISA "deemer clause" dictates that §1722 is preempted to the extent that it would regulate the benefits offered by a self-funded ERISA benefit plan.[8] ERISA preempts any state law that regulates the terms of a self-insured ERISA benefit plan; furthermore, to argue alternatively that such a state law may be applied to *interpret* a plan's substantive terms would be to allow a state to do through the back door, what it may not do via the front. *See*

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[8] *See Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726, 730 (4th Cir. 1992) (so long as ERISA plan can be labeled self-funded, state cannot regulate it); *Thompson v. Talquin Bldg. Prods. Co*, 928 F.2d 649, 652 (4th Cir. 1991) (same).

Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991).

Given the above, the court agrees that, with regard to Plaintiff's claim for medical benefits under the terms of the Fund plan, there are no remaining issues of material fact and judgment must be for Defendants as a matter of law.

V. Defendants' Counterclaim.

A. The Parties' Positions.

According to the above, Defendants had no legal obligation to pay medical benefits to Plaintiff for injuries related to the October, 1990 motor vehicle accident. However, Defendants allege that they did advance $2924.78 in medical benefits relating to Plaintiff's accident. Their counterclaim seeks reimbursement for this amount, under 29 U.S.C. §1132(a)(3)(B). They also seem to argue for judgment under a federal common law theory of unjust enrichment.

As the court stated above, Plaintiff's major argument directed to the counterclaim is that the monies paid were not "advances" but medical benefits payable under the terms of the Fund's plan. Since the issue of reimbursement only arises in the plan documents with regard to advances, Plaintiff contends that reimbursement is not appropriate. Obviously the court's decision on Plaintiff's claim makes this position untenable. Plaintiff also argues, less vociferously, that the Fund plan documents limit the obligation of participants to reimburse the plan to instances where participants gain a settlement or recovery specifically earmarked for medical expenses. She characterizes her settlement with the third party tortfeasors as one for pain and suffering.

B. Discussion.

While 29 U.S.C. §1132(a)(3)(B) does indeed provide for suits to enforce provisions or redress violations of an ERISA plan, its terms explicitly require that such suits be brought by a plan fiduciary. The section does not provide a direct cause of action for the plan itself. Hence, the captioned counterclaim is not proper under §1132(a)(3)(B).

However, the court believes that the approach taken in *Provident Life & Accident Insurance Co. v. Waller*, 906 F.2d 985 (4th Cir.), *cert. denied*, 498 U.S. 982 (1990), is appropriate here. *Provident* concerned the refusal of a plan participant to reimburse an ERISA fund; in that case a plan provision stated,

> Medical disability benefits are not payable to or for a person covered under the Group Plan when the injury ... occurs through the act or omission of another person. However, payment for medical care expenses ... for an injury in which a third party is liable *may be advanced by Provident.* For this to happen, the *covered person must sign an agreement to repay the Group Plan in full any payments advanced* ... from the judgment or settlement he or she receives.

Id. at 986 (emphasis in original). In *Provident*, the ERISA plan advanced about $6,000 worth of medical benefits to a participant despite her failure to sign a repayment agreement. The participant proceeded to collect damages from a third party, and refused to reimburse her plan. *Id.* at 986-87. The Fourth Circuit concluded that it lacked jurisdiction under 29 U.S.C. §1132(a) (the ERISA civil remedies section) because actions available under that provision were limited to the parties cited by its terms. *Id.* at 987-88.

However, the Fourth Circuit went on to explain that federal courts do have original jurisdiction, under 28 U.S.C.

§1331(a), of civil actions arising under federal common law. The court found that since ERISA's broad preemption clause dictated that state contract and tort claims be preempted in favor of the application of ERISA, equitable claims relating to an ERISA plan likewise should be examined under federal ERISA law. Since ERISA itself provided no explicit remedy for the *Provident* plaintiff, the Fourth Circuit found it appropriate to focus on a federal *common law* remedy of unjust enrichment. Such an approach was consistent with the United States Supreme Court's authorization for federal courts "to develop a 'federal common law of rights and obligations under ERISA-regulated plans.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989) (citations omitted). The Fourth Circuit applied the federal common law of unjust enrichment and held that the *Provident* participant must repay her ERISA plan. *Id.* at 993-94. The Fourth Circuit's approach of applying federal common law where ERISA provides the plaintiff no explicit remedy has been followed and/or cited by a number of other courts, including the Third Circuit. *See, e.g., Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1187 (3d Cir. 1991) (federal common law of equitable restitution available as remedy for ERISA plan to recover mistaken payments out of trust corpus; cites *Provident* with approval); *Asbestos Workers Local No. 23 Health and Welfare Plan v. Mackowiak*, Civil Action No. 3:CV-91-416, slip op. at 5-6 (M.D. Pa. December 4, 1991), *aff'd without opinion*, No. 92-7073 (3d Cir. Sept. 24, 1992) (holding federal common law dictated that participant repay ERISA plan as per reimbursement provision in plan). This court will apply the *Provident* approach in the captioned case by deeming Defendants' counterclaim to be one under the federal common law of unjust enrichment and falling within federal question jurisdiction. *See* 28 U.S.C. §1331(a).

"As summarized by a national commentator, three elements encompass the equitable remedy of unjust enrichment ... the plaintiff must show that (1) he had a reasonable expectation of payment, (2) the defendant should reasonably have expected to pay, or (3) society's reasonable expectations of person and property would be defeated by nonpayment." *Provident,* 906 F.2d at 993-94 (citing C. Kaufman, *Corbin on Contracts,* §19A at 50 (Supp. 1989)).

In the captioned case, application of the law of unjust enrichment would further the intent demonstrated in the Fund plan. Two relevant Fund document provisions state the obligation of Fund participants to reimburse advances made by the Fund for otherwise excluded medical claims.[9] This obligation is variously stated as one of assignment of claim, and as one of direct repayment from third party recoveries. It is clear from these two provisions that the Fund did have a reasonable expectation of reimbursement if it advanced bene-

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[9] The Fund Plan states:

> In such circumstances [where coverage is denied because injuries are from accidents where recovery may be had from a third party, etc.], the Fund may determine, in appropriate cases, that because of delays inherent in litigation or the processing of such claims, it will pay the benefits to or on behalf of the worker or dependent conditioned, however, upon receipt of an assignment to the Fund of such worker's or dependent's right to recover for loss, to the full extent payments have been made by this fund.

(Fund Plan document, Defendants' exhibit 3 to Obrenz Aff., at p. 14.) The Fund's Summary Plan Description, states:

> If you have a right to recover payment for an injury or illness from another source, there may be delays because of the time it takes to process the claim or because of lawsuits. If this happens, the Fund may be able to help you temporarily by paying benefits in advance. If this is done, you must sign a legal document stating that the Fund will be repaid in full, from any settlement you receive. The Fund must be repaid to the Full Extent ... of the benefits it provided.

(Summary Plan Description, Defendants' exhibit 5 to Obrenz Aff., at p. 44 (emphasis in original).)

fits that were otherwise precluded by the plan, and that Plaintiff reasonably should have expected to repay any such advancements made by the Fund, from any recovery she gained from a third party.

Plaintiff is incorrect In contending that the Fund documents demonstrate an expectation of reimbursement only if participants have a recovery specifically earmarked for medical expenses. The two relevant Fund provisions clearly and unambiguously provide for assignment of a participant's "right to recover loss," and repayment "from any settlement received." Hence, reimbursement for advances under the terms of the Plan must be made if there is *any* recovery at all from a third party, insurer, etc. *See Dugan v. Nickla*, 763 F. Supp. 981, 984 (N.D. Ill. 1991) (subrogation provision requiring reimbursement "upon any recovery made by an Employee" would be operative no matter how jury apportioned verdict).

Neither party raises as an issue the fact that Plaintiff never signed an Assignment of Claim form, although the Fund explicitly requested that she do so. In *Provident*, the Fourth Circuit found that the fact that benefits were advanced prior to obtaining the participant's signature on a reimbursement form was not material to the result. As the Third Circuit has stated in another context, "under the common law of unjust enrichment, restitution of a mistaken payment is permitted even if payment was caused by the negligence of the party seeking restitution." *Luby*, 944 F.2d at 1186. Here Plaintiff's failure to sign an Assignment form, and any possible negligence of Defendants in advancing funds before obtaining such form, should not bar reimbursement of the funds advanced,[10]

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[10] The Fund documents do not specify that the participant must sign a form *before* any Fund advancements occur. The two cited provisions imply just the

if the reasonable expectations of the parties should have been that reimbursement would occur.

In addition to the parties' expectations, society's reasonable expectations dictate that reimbursement be made to Defendants out of Plaintiff's recovery. Plaintiff has recovered a sizeable settlement.[11] Her failure to reimburse the Fund would allow her to recoup a double recovery for those medical expenses paid by the Fund, while the Fund trust would thereby be depleted. As the *Provident* court concluded, the provisions of ERISA[12] indicate Congress' desire "to ensure that plan funds are administered equitably, and that no one party, not even plan beneficiaries, should unjustly profit." *Provident*, 906 F.2d at 993 (citing *Carl Colteryahn Dairy, Inc. v. Western Pa. Teamsters & Employers Pension Fund*, 847 F.2d 113, 122 (3d Cir. 1988)).

Given the above, Defendants' motion for summary judgment on their counterclaim will be granted. Plaintiff must reimburse all accident-associated medical benefits advanced by the Fund on her behalf. In order to prevent unjust enrichment from interest, equity demands that Plaintiff shall also pay prejudgment interest on those advancements, payable from June 17, 1992, the date of her settlement.

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opposite, that the advancements are made with the understanding that the form will be signed.

[11] While Plaintiff has characterized her settlement as one for pain and suffering, the settlement agreement itself provides that it serves as a discharge for "all claims which have, or might be made." Such claims include "without limitation, any and all known or unknown claims for bodily and personal injuries to Claimant." (Settlement agreement and release, Defendants' exhibits to Obrenz Aff., no. 16.) This settlement language belies Plaintiff's characterization of the settlement. For the terms of the settlement, *see* note 1, *supra*.

[12] The court explicitly cited 29 U.S.C. §1103(c)(2)(A).

While Plaintiff has never challenged Defendants' list of paid claims, the court would prefer to have some record documentation. In their motion, Defendants listed the paid claims, by date of *payment*, amount and provider, but the bills that were actually submitted as exhibits by Defendants are for an unorganized mixture of paid and unpaid claims, and can be categorized only by billing date. Prior to the entry of judgment, if possible, Defendants shall submit to the court a set of discrete bills to match the list they provided in their motion for summary judgment.

Defendants have requested attorney fees and costs under 29 U.S.C. §1132(g)(1); this provision allows a court, in its discretion, to award attorney's fees and costs to either party in an action, such as Plaintiff's, brought under ERISA by a participant, beneficiary or fiduciary.

The most prevalent approach used by courts in awarding costs and fees under §1132(g)(1) is to consider five factors:

> (1) the offending party's bad faith or culpability, (2) the ability of the offending party to pay the fee award, (3) the deterrant effect of an attorney's fee award against others acting under similar circumstances, (4) whether or not the party requesting attorney's fees seeks to benefit all participants or members of the ERISA plan, and (5) the relative merits of the parties' positions.

Home for Crippled Children v. Prudential Ins. Co., 590 F. Supp. 1490, 1508 (W.D. Pa. 1984). *See also Ursic v. Bethlehem Mines*, 719 F.2d 670, 673 (3d Cir. 1983).

The court does not believe that these factors weigh in favor of awarding attorney fees and costs to Defendants. There has been no demonstration of any bad faith on the part of Plaintiff. Her position regarding coverage of her claims by the

Defendants was truly intertwined with her position on reimbursement to Defendants of their advances.

With regard to her own claim, while Plaintiff's position was not adopted by the court, it was certainly not a frivolous one; to the extent that her action resolved an unclear issue regarding the preemptive effect of Pennsylvania law on the terms of the Fund's plan, the action has benefitted both the Fund itself and other plan participants. The court is not certain that the deterrance of actions such as the captioned one is a wise judicial goal.

An appropriate order will issue.

SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: April 9, 1993.

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-92-922

DOROTHY E. TRAVITZ,

Plaintiff

v.

NORTHEAST DEPARTMENT ILGWU HEALTH AND WELFARE FUND AND ILGWU EASTERN STATES HEALTH AND WELFARE FUND,

Defendants

ORDER

In accordance with the accompanying memorandum, IT IS HEREBY ORDERED THAT:

1. Plaintiff's action is deemed one to recover benefits due under the terms of an ERISA plan, as per 29 U.S.C. §1132(a)(1)(B).

2. Plaintiff's motion for summary judgment is DENIED.

3. Defendants' motion for summary judgment is GRANTED as to Plaintiff's claim for benefits under the terms of the Defendants' plan. Judgment will be entered for the Defendants and against the Plaintiff on Plaintiff's claim.

4. Defendants' counterclaim for reimbursement of advanced funds is deemed one under 28 U.S.C. §1331.

5. Defendants' motion for summary judgment is GRANTED as to Defendants' counterclaim. Judgment, including prejudgment interest, will be entered for the Defendants and against the Plaintiff on Defendants' counterclaim. Prejudgment interest will be calculated according to 28 U.S.C. §1961(a). However, the taxing of costs and attorney fees is DENIED.

6. The clerk of court will defer the entry of judgment on the counterclaim until Defendants submit additional information in the form of bills or other documentary support for the monies claimed, as per the court's memorandum of law.

7. Defendants shall submit the latter information to the court by April 21, 1993.

SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: April 9, 1993.

IN THE UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-92-0922

DOROTHY E. TRAVITZ,

Plaintiff

v.

NORTHEAST DEPARTMENT ILGWU HEALTH AND WELFARE FUND AND ILGWU EASTERN STATES HEALTH AND WELFARE FUND,

Defendants

ORDER AND JUDGMENT

On April 9, 1993, this court entered summary judgment for Defendants, directing them to make certain record submissions relating to their counterclaim. Defendants having responded, IT IS HEREBY ORDERED THAT:

1. Judgment is entered for Defendants on their counterclaim against Plaintiff in the amount of $2,924.78, plus prejudgment interest, calculated pursuant to 28 U.S.C. §1961(a), from June 17, 1992 (date of Plaintiff's settlement) until May 11, 1993. This judgment shall become effective on Tuesday, May 11, 1993, unless this court orders to the contrary.

2. Plaintiff shall make any objection to the judgment figure known to this court by May 10, 1993.

SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: April 28, 1993.

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF PENNSYLVANIA

CIVIL ACTION NO. 1:CV-92-0922

DOROTHY E. TRAVITZ,

Plaintiff

v.

NORTHEAST DEPARTMENT ILGWU HEALTH AND WELFARE FUND AND ILGWU EASTERN STATES HEALTH AND WELFARE FUND,

Defendants

ORDER

On April 9, 1993, this court entered summary judgment for Defendants, directing them to make certain record submissions relating to their counterclaim. On April 28, 1993, this court entered judgment, effective May 11, 1993, and gave Plaintiff to May 10, 1993 to file any objections. No objections have been received.

Accordingly, IT IS HEREBY ORDERED THAT:

1. The entry of judgment for Defendants on their counterclaim against Plaintiff in the amount of $2,924.78, plus prejudgment interest, calculated as per 28 U.S.C. §1961(a), from June 17, 1992 (date of Plaintiff's settlement) until May 11, 1993 is confirmed, effective as of May 11, 1993.

2. Judgment is entered in favor of Defendants and against Plaintiff on Plaintiff's claim for benefits under the terms of the Defendants' plan.

3. The Clerk of Court is directed to close the file.

SYLVIA H. RAMBO, Chief Judge
Middle District of Pennsylvania

Dated: May 17, 1993.

Filed January 10, 1994

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

NOS. 93-7277, 93-7334, and 93-7383

DOROTHY E. TRAVITZ, Appellant

v.

NORTHEAST DEPARTMENT ILGWU HEALTH AND WELFARE FUND; ILGWU EASTERN STATES HEALTH AND WELFARE FUND

Appeal from the United States District Court for the Middle District of Pennsylvania

D.C. No. 92-00922

Argued November 8, 1993

Before: GREENBERG, COWEN, and ROSENN, *Circuit Judges*

Opinion Filed January 10, 1994

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(Argued)
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OPINION OF THE COURT

ROSENN, *Circuit Judge.*

Pennsylvania enacted the Motor Vehicle Financial Responsibility Law (the Act) of which §1722 precludes a person from recovering damages arising out of the use of a motor vehicle from a culpable tortfeasor if the claimant is otherwise eligible to receive those benefits from any program, group contract, or other arrangement, as defined by the Act. 75 Pa. Cons. Stat. Ann. §1722 (1977 & 1993 Supp.). The primary issue raised on this appeal is whether the Act is preempted by the Employee Retirement Income Security Act of 1974, (ERISA,. 29 U.S.C. §1001 *et seq.* The district court, on cross-motions for summary judgment, answering in the affirmative, entered judgment in favor of the defendants. We affirm.[1]

I.

Appellees, the Northeast Department, ILGWU Health and Welfare Fund and its successor in interest, the ILGWU Eastern States Health and Welfare Fund (the Fund), operate a multi-state, multi-employer health and welfare plan within the meaning of ERISA, 29 U.S.C. §1002(1).[2] The Fund, which is self-insured, is governed by a basic plan and rules of the Northeast Department, ILGWU. In addition, the Fund is also operated and maintained pursuant to rules set forth in a written document, the Summary Plan Description (collec-

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[1] The district court exercised subject matter jurisdiction pursuant to 29 U.S.C. §1001 *et seq.* as the action constituted a suit under 29 U.S.C. §1132(a)(1)(B) to recover benefits due under a covered plan, and pursuant to 28 U.S.C. §1331(a) as the counterclaim arose under federal common law. We have jurisdiction under 28 U.S.C. §1291.

[2] Effective January 1, 1990, the Northeast Department ILGWU Health and Welfare Fund merged into the ILGWU Eastern States Health and Welfare Fund, which is the surviving plan of the merger. The Fund is now known as the ILGWU Eastern States Health and Welfare Fund.

tively, the Plan). The Plan provides medical, disability, and preventative health care benefits to employees of contributing union employers and the Fund remains solely responsible for the payment of such benefits. The Plan further provides various exclusions with respect to benefits it offers. Exclusion 5 sets forth that members of the program "can not* receive benefits/coverage for a condition if the costs of treating that condition are recoverable through legal action or claim settlement from another party or insurance company."

Appellant, Dorothy E. Travitz, an employee of BR Apparel, Inc., a member of the international Ladies' Garment Workers' Union (ILGWU), and a participant in the union's health and welfare program, sustained serious injuries in a motor vehicle accident on October 18, 1990. As a result, she incurred medical bills exceeding $65,000. She received $10,000 in first party medical benefits under her motor vehicle insurance policy. After exhausting those benefits, she submitted for payment numerous claims relating to treatment and services for her injuries to the providers of the union's benefit program, the Fund. The Fund, pursuant to its Advance of Benefits Provision,[3] paid a total of $2,924.78 of medical benefits to Travitz. In accordance with this provision, the Fund also sought assurances from Travitz that she would eventually repay the amounts received as advances and requested that she sign an assignment of claim form. Travitz refused to

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[3] The provision provides, in pertinent part:

> If you have a right to recover payment for a* injury or illness from another source there may be delays because of the time it takes to process the claim or because of lawsuits. If this happens, the Fund may be able to help you temporarily by paying benefits in advance. If this is done you must sign a legal document stating that the Fund will be repaid in full, from any settlement you receive. The Fund must be repaid to the Full Extent ... of the benefits it provided. ... (Emphasis in original).

provide those assurances and did not execute the form. The Fund, therefore, ceased advancing benefits to Travitz.

Travitz also filed a claim against the tortfeasor alleging negligence in the operation of a motor vehicle. Eventually, the claim was settled. The agreement provided that in exchange for a release from liability, Travitz would receive $125,000 in immediate cash, four guaranteed scheduled payments ranging from $10,000 to $30,000, plus $1,030 per month for life with fifteen years guaranteed.

Subsequently, Travitz initiated suit against the Fund in the United States District Court for the Middle District of Pennsylvania seeking payment by the Fund of the outstanding medical benefits claimed to be due her, costs, and bad faith damages. In her complaint, she alleged that the Fund improperly relied upon coverage Exclusion 5 to deny her these medical benefits in the face of the Act's provision that precluded the recovery of medical expenses from a tortfeasor when they were payable under the medical benefit program she had with the Fund.[4]

In effect, she claimed that the medical benefits were recoverable only from the Fund regardless of the coverage exclusion of the Plan because the Act precluded her from recovering them from the tortfeasor. Section 1722 provides:

> In any action for damages against a tortfeasor ... arising out of the maintenance or use of a motor vehicle, a person who is eligible to receive benefits under the coverages set forth in ... any program, group contract or other arrangement for payment of benefits as defined in

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[4] Travitz characterizes the settlement she received from the tortfeasor as one for pain and suffering. The Fund does not provide benefits for pain and suffering and thus, in accordance with her interpretation, Section 1722 did not preclude the recovery of those benefits from the tortfeasor.

> section 1719 (relating to coordination of benefits) shall be precluded from recovering the amount of benefits paid or payable under ... any program, group contract or other arrangement for payment of benefits as defined in section 1719.

75 Pa. Cons. Stat. Ann. §1722 (1977 & 1993 Supp.). The Fund argued, however, that Exclusion 5 of their Plan is applicable and therefore its medical benefits were unavailable to Travitz. Accordingly, the Fund contended that her only recourse was to pursue the tortfeasor. In addition, the Fund counterclaimed for reimbursement of payments totaling $2,924.78 advanced to Travitz.

Chief Judge Rambo of the district court on cross-motions for summary judgment held that the Fund is a multi-employer health and welfare plan within the meaning of ERISA, and that §1722 of the Pennsylvania Act is preempted by the self-insured ERISA benefit plan. Consistent with her opinion, the court found for the Fund on its counterclaim and ordered that Travitz reimburse it the $2,924.78 advanced along with prejudgment interest. Travitz appealed.

II.

The issue of preemption is essentially legal and our review of the district court's summary judgment holding is therefore plenary. *See Wheeler v. Towanda Area School Dist.*, 950 F.2d 128, 129 (3d Cir. 1991). On appeal we apply the same test the district court should have used in the first instance. *See Goodman v. Mead Johnson & Co.*, 534 F.2d 566, 573 (3d Cir. 1976), *cert. denied*, 429 U.S. 1038 (1977). We therefore affirm only if there are no genuine issues of material fact and the relevant law entitles the moving party to judgment.

Travitz's arguments on appeal are legal in nature. She basically argues two principal points which seem to be inter-

twined. First, although section 1722 "relates to" employee welfare plans, it lacks a "connection with" such plans and falls within the "remote and peripheral" exception to ERISA preemption. Second, that the supposed conflict between Section 1722 and Exclusion 5 of the Plan is essentially an issue of interpretation rather than one of preemption, and should be interpreted in a manner consistent with the Fund's requirements. In effect, she claims that Exclusion 5 cannot be used to deny her medical benefits from the Fund because her recovery from the tortfeasor did not encompass those benefits; rather they were limited to pain and suffering only. Therefore, she argues, the Fund must reimburse her for those presently unrecovered expenses.

We turn first to three ERISA statutory provisions dealing with the question of preemption. These provisions in Section 1144 of ERISA state in relevant part:

> Except as provided In subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. ...

29 U.S.C. §1144(a)(1988) (preemption clause)

> Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

Id. §1144(b)(2)(A) (saving clause)

> Neither an employee benefit plan ... nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any

> State purporting to regulate insurance companies, insurance contract, banks, trust companies, or investment companies.

Id. §1144(b)(2)(B) (deemer clause)

As the Supreme Court has explained, the broadly worded preemption clause "establishes as an area of exclusive federal concern the subject of every state law that 'relate[s] to' an employee benefit plan governed by ERISA." *FMC Corp. v. Holliday,* 498 U.S. 52, 58 (1990). The saving clause expressly reserves to the states the power to regulate insurance; the deemer clause, however, precludes a state from regulating an employee benefit plan governed by ERISA in the guise of regulating insurance companies. *See id.*

Our first inquiry, under these provisions, is whether Section 1772 "relate[s] to" an employee benefit plan. A law relates to an employee welfare plan if it has "a connection with or reference to such a plan." *Shaw v. Delta Air Lines Inc.,* 463 U.S. 85, 97 (1983). Section 1722, which precludes the recovery of benefits from a tortfeasor where a person is eligible to receive those benefits under another program, group contract or arrangement, as defined in Section 1719, has "reference" to benefit plans governed by ERISA. *See FMC,* 498 U.S. at 59, Section 1719(b) of the Act states that "the term 'program, group contract or other arrangement' includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation." 75 Pa. Cons. Stat. Ann. §1719(b) (1977 & 1993 Supp.)

In addition, Section 1722 has a "connection" to ERISA benefit plans. The Court has held that state laws have a "connection" to an ERISA plan when the laws risk subjecting plan administrators to conflicting state regulations. *See FMC,* 498 U.S. at 59. Section 1722 has that very effect. In states with

a provision like Section 1722, the Fund, rather than a tortfeasor, would be primarily liable. Therefore, in structuring its program, a health and welfare benefit plan would have to consider its ultimate liability and adjust the level of benefits accordingly. Thus, plan administrators would be unable "to calculate uniform benefit levels nationwide." *Id.* at 60. To ensure that ERISA would be governed by a "uniform administrative scheme, which [would] provide[ ] a set of standard procedures to guide processing of claims and disbursement of benefits," Congress preempted state laws "connected" to ERISA. *Id.* (quoting *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1, 9 (1987)).

Travitz's contention that Section 1722's effect on ERISA plans is "too tenuous, remote, or peripheral ... to warrant a finding that the law 'relates to' the pla,." *Shaw*, 463 U.S. at 100 n.21, is unavailing. Several factors have been examined in analyzing whether a state law falls within the "remote and peripheral" exception to §1144. Those factors include: (1) whether the state law represents a traditional exercise of state authority; (2) whether the state law affects relations among the principal ERISA entities—the employer, the plan, the plan fiduciaries, and the beneficiaries—rather than relations between one of these entities and an outside party or between two outside parties with only an incidental effect on the plan; and (3) whether the effect of the state law upon the ERISA plan is direct or merely incidental. *Firestone Tire & Rubber Co. v. Neusser,* 810 F.2d 550, 555-56 (6th Cir. 1987).

Application of the foregoing factors compels the conclusion that Section 1722 is preempted by ERISA. Although, in specifying the damages that may be recovered from a tortfeasor, Section 1722 arguably represents a traditional exercise of state power, the remaining factors referred to above clearly tilt

the balance against Travitz. Section 1722, by shifting ultimate liability for medical and health care benefits to the ERISA Fund, has a direct and possibly devastating effect on it. That effect implicates the relations between the principal parties—the Fund and its beneficiaries—by requiring the Fund to pay Travitz's medical benefits and by making less overall benefits available to the other beneficiaries of the Fund. Thus, the exception set forth in *Shaw* is not applicable and, unless saved by another ERISA provision, Section 1722 will be preempted. Arguably, Section 1722 falls within the purview of the saving clause which specifically reserves the regulation of insurance to the states.

Although, on its face, the statute does not seem to be regulating insurance, it is part of a broad-based law which not only has an impact on insurance companies but is also specifically directed towards that industry. *See Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 50 (1987). The deemer clause, however, would proscribe a state from regulating self-insured ERISA plans. The clause provides that states are forbidden to deem ERISA plans "to be an insurance company or other insurer." 29 U.S.C. §1144(b)(2)(B). Therefore, even if a state law is saved because it regulates insurance it has no effect on self-insured ERISA plans by virtue of the deemer clause. *See FMC,* 498 U.S. at 61.

Thus, we hold that Section 1722 of the Pennsylvania Motor Vehicle Financial Responsibility Law or any state statute that attempts to shift liability for medical and health care benefits to a plan, group contract or other arrangement operating within the meaning of ERISA is preempted by it.[5]

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[5] Although *United Wire, Etc. v. Morristown Memorial Hospital,* 995 F.2d 1179 (3d Cir.), *cert. denied,* 114 S.Ct. 382 (1993), not cited by any of the parties, reached a contrary result in construing a New Jersey statute pertaining to hospital

Travitz persists in arguing, however, that notwithstanding its preemption, Section 1722 should still be interpreted to apply because it can be read as consistent with the exclusions in the Fund's Plan. Travitz is mistaken. The court has held that preemption is not precluded "simply because a state law is consistent with ERISA's substantive requirements." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (citing *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985)). Moreover, Section 1722 and Exclusion 5 of the Fund's Plan are in no way consistent. Both attempt to shift the responsibility for the payment of benefits to another source.

It is ironic that in her attempt to construe the provisions as consistent with each other, Travitz is endeavoring to circumvent the purpose of both provisions. By arguing that she could not have received medical benefits from her settlement with the tortfeasor because of Section 1722's restriction, she is seeking to recover twice for the same injury. Her classification of the settlement as one for pain and suffering rather than for medical benefits is disingenuous, in the face of the language of the settlement agreement she executed which provides a discharge for "all claims," including those for "personal injuries." Travitz's characterization of the settlement award underscores the need to have but one provision dealing with benefits. Provisions enacted pursuant to ERISA would thus govern and Section 1722 of the Pennsylvania Act must therefore be preempted with respect to the Fund's self-insured ERISA plan. Accordingly, as Section 1722 is preempted it cannot and could not have prevented Travitz from recovering medical

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rates, the case is inapposite on its facts. Unlike the case *sub judice*, the state law in *United Wire* did "not have either the effect of dictating or restricting the manner in which ERISA plans structure or conduct their affairs or the effect of impairing their ability to operate simultaneously in more than one state." *United Wire*, 995 F.2d at 1195.

benefits from the tortfeasor. Consequently, under the plain terms of Exclusion 5 which is controlling, the Fund is not responsible for the medical benefits because they were recoverable from the tortfeasor.

In her statement of the issues presented for review, Travitz also asserts that the district court erred in granting summary judgment in favor of the Fund with respect to its counterclaim for the $2,924.78 advanced to her, along with prejudgment interest. Under Fed. R. App. P. 28(a)(5), an appellant is required to list the issues raised on appeal and present an argument in support of them. *Simmons v.* City of *Philadelphia,* 947 F.2d 1042, 1065 (3d Cir. 1991) ("absent extraordinary circumstances, briefs must contain statements of all issues presented for appeal, together with supporting arguments and citations."), *cert. denied,* 112 S.Ct. 1671 (1992). When an issue is not pursued in the argument section of the brief, the appellant has abandoned and waived that issue on appeal. *Nagle v. Alspach,* 1993 WL 427246 (3d Cir. 1993); *Kost v. Kozakiewicz,* 1 F.3d 176, 182 (3d Cir. 1993); *Institute for Scientific Info., Inc. v. Gordon & Breach, Science Publishers, Inc.,* 931 F.2d 1002, 1011 (3d Cir.), *cert. denied* 112 S.Ct. 302 (1991); 16 Charles A. Wright, et al., *Federal Practice and Procedure* §3974, at 421 (1977 & Supp. 1993, at 690) (issue must be raised in both the issues and argument sections of the brief).

In the present case Travitz completely fails to articulate or pursue these issues. Neither does she attempt to argue extraordinary circumstances which might excuse her failure to argue these issues. We therefore conclude that Travitz has abandoned and waived these issues and we refuse to address them.

Accordingly, the judgment of the district court will be affirmed. Costs taxed to the appellant.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
for the Third Circuit

Summary Plan Description

In accordance with the Employee Retirement Income Security Act of 1974 (ERISA), the following information is provided to benefit plan participants and beneficiaries with respect to their hospital and medical-surgical coverage, and welfare benefits as a means to a better understanding of the operation of that plan and the benefits it provides:

1. Name of Benefit Plan
   Northeast Department I.L.G.W.U. Health and Welfare Fund

2. Plan Sponsor **Board of Trustees**
   Northeast Department I.L.G.W.U. Health and Welfare Fund
   Address: **218 West 40th Street, New York, NY 10018**

3. Identification Number (EIN) **6019360**

4. Benefit Plan Number **501**

5. Type of Benefit Plan
   Hospital, Medical Services, Disability, Cash Welfare

6. Type of Plan Administration **Board Of Trustees**

7. Plan
   Name: **Board of Trustees**
   Northeast Department I.L.G.W.U.
   Health and Welfare Fund
   Business Address:
   218 West 40th Street, New York, NY 10018
   Business Telephone Number: 212/398-3900

8. Agent for Service of Process
   Ralph R. Reuter, Administrator
   Northeast Department I.L.G.W.U. Health and Welfare Fund
   218 West 40th Street, New York NY 10018

9. Trustees of Benefit Plan

Sol Hoffman, Chairman
Ronald Alman, Vice Chmn.
Joseph Fisher, Vice Chmn.
Martin Berger
Sam Bianco
Lillian Brodeur
Harvey Gold
Isaac Gordon
Stanley Gross
Lois Hartel
Ada Jakubic
Julia Kamel
Earl Laub
Thomas Mathews
Yvonne Patz
Ralph Reuter
Joseph Rotell
Nicholas Roussos
Richard Rumelt
Nathan Sandler
Frank Trykoski
Joseph Vetro

All of the above may be contacted at: 218 West 40th Street, New York, NY 10018

10. Collective Bargaining Agreements

This Plan is established under Collective Bargaining Agreements between the Union and Employers. The "Union" means International Ladies' Garment Workers' Union or a subordinate body thereof. The provision of the Union contracts also set the rate of contributions the employers are required to make in order to finance the benefits provided by the Plan.

September, 1985

General Exclusions and Limitations

The information in this section applies to all of the benefits that the Fund offers. It is not repeated in each specific section, but it applies anyway.

Exclusions

1. You can not* receive benefits/coverage for any illness or injury resulting from an act of war.

2. You can not* receive benefits/coverage for any illness or injury which was caused by your job or suffered in connection with your work. You may be paid for these through insurance carried by your employer under Workers' Compensation laws.

3. You will not be covered for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance, including no fault, liability, medical payment, uninsured motorist or a certified self-insured plan, or payable by the Catastrophic Loss Trust Fund established under the Pennsylvania Motor Vehicle Financial Responsibility Law.

4. If medical services are provided to you without cost by any governmental agency, you can not* receive benefits/coverage for those services. A Veterans Administration hospital, Medicare (for active workers over the age of 70) and Welfare are all examples of governmental agencies.

5. You can not* receive benefits/coverage for a condition if the costs of treating that condition are recoverable through legal action or claim settlement from another party or insurance company.

6. Services related to dental care are not covered.

General Exclusions and Limitations

7. Services related to cosmetic surgery are not covered unless the surgery is necessary to correct a birth defect or if it is necessary to correct a condition caused by injury which occurred after you became eligible for benefits.

8. There are some disabilities for which you cannot receive benefits, such as: Invalidism, convalescence or rest cures for various indefinitely diagnosed conditions, asthenia, general arteriosclerosis, general debility, low blood pressure, or simple hypertension, chronic illnesses, except as provided in the rules, common cold and grippe, oral surgery, menopause, alcoholism, drug addiction, unproven or mild secondary anemia or indefinite endocrine or nervous ailments including anxiety, spastic or irritable colon, or mucous colitis following definite diagnosis. If, however, any such condition results in hospitalization or institutionalization of an otherwise eligible covered worker, the Trustees' Appeal Committee may allow such full or partial benefits as it may in its sole discretion determine.

Limitations

1. You can not* receive benefits for pre-existing conditions until you have been a covered worker in the Fund for 12 months in a row. If you received medical advice or treatment for an illness or injury any time before you were eligible for benefits from this Fund, that condition will be considered a pre-existing condition.

2. Benefits are not provided for in-patient hospital services if, in the Fund's opinion, the service could have been reasonably done on an outpatient basis.

3. Benefits are not provided for the following types of hospital admissions if, in the Fund's opinion, the services could have been provided in another setting. This rule can also be applied to a *portion* of a hospital admission. Some examples are:

General Exclusions and Limitations

A. Admissions for observation, evaluation or diagnosis which could have been safely done on an outpatient basis.

B. Admissions to control or change the patient's environment.

C. Admissions for custodial care. This is defined as use of in-patient hospital services and supervisory care by a doctor for a person who is disabled but is not receiving treatment which is likely to reduce the disability or enable the patient to live outside an institution.

D. Admissions for convalescent care or rest cures.

E. Admissions for domiciliary care. This is defined as use of in-patient hospital services because care in the home is not available or not suitable.

4. The fact that a physician may prescribe, recommend or approve a service or supply does not necessarily mean that it is medically necessary or a covered service. The Fund will determine if coverage is suggested by the medical information available.

Advance of Benefits

If you have a right to recover payment for an injury or illness from another source, there may be delays because of the time it takes to process the claim or because of lawsuits. If this happens, the Fund may be able to help you temporarily by paying benefits in advance. If this is done, you must sign a legal document stating that the Fund will be repaid in full, from any settlement you receive. The Fund must be repaid to the ***Full Extent*** (without deduction of attorney fees, court costs, or arbitration costs) of the benefits it provided. The Fund may also require legal assurances that the party which is liable to you will honor your claim and that the money due to

you will be repaid directly to the Fund. In all cases, only the Trustees of the Fund can decide whether an advance of benefits is appropriate. Each case will be decided on its own merits.

If you are denied benefits from the Fund because the Fund or its agents believe that payment is recoverable from another source, you may appeal that decision directly to the Board of Trustees. See page 49 for information on the procedure for this type of appeal.

Coordination of Benefits

What happens if you are covered for a type of benefit under this Plan and you also are covered for the same benefits under another plan? Benefits under this Plan shall be coordinated with those provided by other plans so that the total amount of benefits available to you or your dependent will not exceed those that would be provided by the plan that would pay the larger benefit for any type of coverage. For purposes of this section "plan" means:

1. Group, blanket or franchise insurance coverage, including those for students for educational institutions;

2. Blue Cross, Blue Shield, group practice, individual practice, and other prepayment coverage;

3. coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

4. coverage under any tax-supported or any government program to the extent permitted by law; and

5. automobile insurance of all kinds.

If more than one plan covers a particular type of expense, benefits shall be paid by the primary plan until the coverage of you or your dependent under that plan is exhausted. The

secondary plan shall pay as benefits the difference between what has already been paid by the primary plan and what it would have paid had it been the primary plan. To determine which plan is the primary plan, the following rules shall apply

A. All types of automobile insurance shall be primary;

B. a plan without coordination of benefits provision shall be primary;

C. Medicare shall be primary, if you elect it to be;

D. all other government funded or mandated plans shall be primary.

In other situations, the following rules shall determine which is primary:

1. The plan covering the patient directly, rather than as an employee's dependent, is primary and the others secondary.

2. If a child is covered under both parents' plans, the father's plan is primary.

3. If neither 1 nor 2 apply, the plan covering the patient longest is primary.

You may not be covered at all for treatment or services for a particular illness or injury because of the General Exclusion Rules (page 43). For example, generally treatment of injuries resulting from automobile accidents are excluded. If the services might be covered because of an exception to the General Exclusion rules, then these Coordination Rules will apply.

Appeals Procedures

If you disagree with a decision on your claim, there are procedures you can use to try to have the decision changed. These are called Appeals Procedures. The Standard Appeals Procedure, which is used to appeal decisions made by the Fund, starts at your local district office. However, if you disagree with a decision made by Blue Cross or Blue Shield, acting as the Fund's agent a different Appeals Procedure is used. Further, there are two specific circumstances in which you can appeal directly to the Board of Trustees of the Fund.

In all cases, there is a specific set of steps that you must go through to appeal a decision. To have the best chances of success, follow the procedure as closely as possible.

Standard Appeals Procedure

If your claim is denied by the Fund, in whole or in part, you will receive a written notice from your district office. It will explain the specific reasons that your claim was denied.

Step 1: Appeal To The District Appeals Committee

Every district office has a District Appeals Committee made up of workers and/or staff from the local area. The District Appeals Committee is the first place where your appeal can be taken up.

To file an appeal, you must write a letter to the District Appeals Committee of your district office.

- The letter must be received *within 60 days* after you receive the notice about your claim.
- The letter must state that you *wish to appeal* the Fund's decision.
- If you wish to be present at the meeting in order to explain your case, you should say so in your letter. If you do

not specifically ask for a "hearing" (explaining your case to the Committee in person), then the Committee will decide the case on the basis of the information in your letter and other available records.

The District Appeals Committee will schedule a meeting and issue a decision promptly. In no event will more than 120 days pass between the time you request an appeal and the time that the Committee decides on your case.

PROTECTION OF EMPLOYEE BENEFIT RIGHTS
GENERAL PROVISIONS

§1001. Congressional findings and declaration of policy

(a) Benefit plans as affecting interstate commerce and the Federal taxing power. The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in

such plans; that owing to the inadequacy of current minimum standards, the soundness and stability of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated, employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries. It is hereby declared to be the policy of this Act to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

(c) Protection of interstate commerce, the Federal taxing power, and beneficiaries by vesting of accrued benefits, setting minimum standards of funding, requiring termination insurance. It is hereby further declared to be the policy of this Act to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with

significant periods of service to meet minimum standards of funding, and by requiring plan termination insurance.

(Sept. 2, 1974, P. L. 93-406, Title 1, Subtitle A, §2, 88 Stat. 832.)

§1144. Other laws

(a) Supersedure; effective date. Except as provided in subsection (b) of this section, the provisions of this title and title IV shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) [29 USCS §1003(a)] and not exempt under section 4(b) [29 USCS §1003(b)]. This section shall take effect on January 1, 1975.

(b) Construction and application. (1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 4(a) [29 USCS §1003(a)], which is not exempt under section 4(b) [29 USCS §1003(b)] (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law, of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 506 of this Act [29 USCS §1136].

(4) Subsection (a) shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a)—

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle [29 USCS §§1021 et seq., 1101 et seq.], and the preceding sections of this part [29 USCS §§1131 et seq.] to the extent they govern matters which are governed by the provisions of such parts 1 and 4 [29 USCS §1021 et seq., 1101 et seq.], shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after the date of the enactment of this paragraph [enacted Jan. 14, 1983]), but the Secretary may enter into cooperative arrangements under this paragraph and section 506 [29 USCS §1136] with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 [29 USCS §§1021 et seq., 1101 et seq.] and the preceding sections of this part [29 USCS §1131 et seq.]. (6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.

(B) The Secretary may, under regulations which may be prescribed by the Secretary, exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement or each arrangement which is a member of such class meets the requirements of section 3(1) and section 4 [29 USCS §§1002(1), 1003] necessary to be considered an employee welfare benefit plan to which this title applies.

(C) Nothing in subparagaph (A) shall affect the manner or extent to which the provisions of this title apply to an employee welfare benefit plan which is not a mul-

tiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 206(d)(3)(B)(i) [29 USCS §1056(d)(3)(B)(i).

(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act [42 USCS §§1396 et seq.], to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act [42 USCS §§1396 et seq.].

(c) Definitions. For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the

District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this title.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited. Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b) [29 USCS §§1031, 1137(b)]) or any rule or regulation issued under any such law.

(Sept. 2, 1974, P. L. 93-406, Title I, Subtitle B, Part 5, §514, 88 Stat. 897; Jan. 14, 1983, P.L. 97-473, Title III, §§301(a), 302(b), 96 Stat. 2611, 2613; Aug. 23, 1984, P. L. 98-397, Title I, §104(b), 98 Stat. 1436; Apr. 7, 1986, P. L. 99-272, Title IX, Subtitle B, §9503(d)(1), 100 Stat. 207; Dec. 19, 1989, P. L. 101-239, Title VII, Subtitle G, Part V, Subpart D, §7894(f)(2)(A), (3)(A), 103 Stat. 2450, 2451.)

•Errata in original.